Clinical Advisory Panel
Meeting Notes

March 9, 2001 - 980 Ninth Street, 5th Floor, Sacramento

Panel Members Present

Antonio Linares, M.D., Peter J. Panzarino, Jr., M.D., Herbert A. Berkoff, M.D., David Bergman, M.D., John Alksne, M.D., and Edward Savage, Jr., M.D.

Introductions

Jim Tucker, Chief Deputy Director and Antonio Linares, M.D., Medical Advisor to the Director, opened the second meeting of the Clinical Advisory Panel.

Presentation by CHDR/Maximus, Independent Medical Review Contractor

Tom Naughton, Director, Center for Health Dispute Resolution (CHDR), California, and Dr. Weiss, CHDR California Medical Director, provided an outline of the Independent Medical Review (IMR) services being performed for the Department of Managed Health Care since January 1, 2001.

- CHDR has specialized in medical dispute resolutions since its founding in 1988. With headquarters in Pittsford, New York, CHDR has four other offices, including the Rancho Cordova office in California. It provided approximately 24,000 reviews for Medicare in the year 2000 which included assessing both medical and coverage determinations. CHDR serves 16 state clients. Over 90,000 reviews have been conducted using a two-tiered system with 32 appeal officers (nurses and attorneys) working with over 300 consulting physicians. Services include opinions relying on evidence-based medicine, telephonic reviews and hearings and mediation services. It was accredited in June 2000 by URAC when the first group of independent medical review companies were subject to a national accreditation standard.

- CHDR is a subsidiary of Maximus, an NYSE traded company which began in 1975 with its goal being to provide public service contracts and services and now has over 110 offices across the country. CHDR is part of the Health Management Services Division of Maximus.

- Medical consultant credentials are monitored by a full-time professional relations staff and a Credentials Committee audited by URAC, subject to written standards. CHDR has over 80 California-licensed reviewers and is actively searching for and recruiting additional specialists.

- Panel members asked Mr. Naughton and Dr. Weiss for clarification on several aspects of the review system and process.

- Identifying qualified physicians: The CHDR representatives indicated that the company's practice has been to locate qualified reviewers primarily from the northern New York area and others from personal references of reviewers that have been working with CHDR. With California's program, CHDR is increasing its efforts to enlist California-licensed providers.

- Determining expertise for a particular case: Dr. Weiss noted that reviewers are matched to the issues presented in the case submitted for review based on a credentialing file similar to that used by hospitals. Dr. Weiss acknowledged that the qualifications under URAC and NCQA requirements are higher than basic hospital credentialing, given the importance and significance of the work product. The appeal officer and the CHDR medical director's office will confer, as needed. If problems are found, the issue goes to Dr. Weiss for further review and action.

- Dr. Bergman indicated concern that: only one reviewer would be assigned for a medical necessity review. DMHC staff noted that CHDR and the Department could elect to have more than one reviewer assigned to a medical necessity case when the facts and circumstances warranted it. Three reviewers are assigned to experimental/investigational reviews.

- Dr. Savage asked about the relationship of the Sacramento office with Maximus. Mr. Naughton noted that the CHDR office is co-located with Maximus. There are two appeal officers in the Sacramento office and others will be assigned from the New York office.

HMO Help Center Update

Alan Smith, IMR Project Manager, HMO Help Center, presented an overview of the Help Center staff as it relates to the IMR process and the database system used to track cases through completion. The results of the reviews requested and received were summarized for the Panel.

Public Comment

- Naomi Meyers, Consumers Union, noted that they appreciated the standardization efforts that IMR would bring to plan decision-making, and the Department's willingness to involve consumers in the process.

- Dr. Richard Lehrfeld, from Blue Cross, expressed concern that "off-the-wall" requests could be eligible for review by the IMR process, either for medical necessity or for experimental/investigational denials. Jim Tucker, DMHC Chief Deputy Director, noted that it is the Department that makes the decision, noting that there are wide disparities in how plans categorize their actions and word their denials.

- Dr. Bill Cunningham, PacifiCare, noted that determining whether reviews should be reviewed on an expedited basis is an important decision from the outset of the Department's actions. He believes there is a risk in expediting cases unless absolutely necessary since it puts increased pressure on obtaining medical records as well as the reviewers' decision making. Alan Smith noted that the involvement of the requesting or treating physician is obtained. Dr. Cunningham advised there seems to have been inconsistent determinations and encouraged the Department to review this aspect of the system.

- Kate Dougherty, U.S. Behavioral Health, noted that CHDR must have adequate resources in order to ensure that the system works timely and meets its expectations.

- Danielle Leskin from Blue Cross asked what questions are posed to the reviewers if they are different from those used under the previous IMR system. Mr. Naughton noted they are similar for medical necessity cases.

- Ellen Kaufman from the Institute for Medical Quality noted there were fewer experimental and investigational IMR cases expected in January and February 2001, given the recent history under the Friedman-Knowles Act. Alan Smith noted that the HMO Help Center advised an applicant in writing if an application for IMR is not accepted for review.

- Katrina Paltrow from PacifiCare noted the plan is aware that many enrollees go to the Department for assistance directly, without contacting the plan. She noted a pilot project where the plan is connected by a three-way conference call for such complaints and would welcome the chance to extend the system for resolving IMR applications or phone calls.

Dr. Savage asked about the educational efforts in order to advise enrollees and patients of the opportunity to apply for IMR. Tom Gilevich, DMHC counsel, noted that the plans are required to provide information about IMR when making changes to requested medical treatment and to include an application. The ongoing efforts of the Office of Patient Advocate and the Education and Access Subcommittee of the Advisory Committee on Managed Care were also mentioned as working on additional patient and provider information about enrollee rights, including grievances and assistance available from DMHC such as IMR.

Oversight of IMR Quality Standards

Tom Gilevich reviewed the Quality Assurance processes for the Department's IMR process. Dr. Weiss summarized his role in the CHDR and QA process. Dr. Panzarino expressed an interest in seeing actual case reviews. Dr. Linares summarized how the HMO Help Center and his office coordinate quality-of-care complaints whether the case results in an IMR or not.

Informational Items

- Tom Gilevich noted the ongoing retrospective study being conducted by The Institute for Medical Quality designed to assess the results of the former IMR system.

- Dr. Linares provided the Panel with the status of the Department's interagency agreements with the UCDavis Medical Center and the UCSF Medical School to review quality of care complaints that are presented to the HMO Help Center, assessing IMR results and other projects requiring research or specialty support to the Department. Dr. Wade Aubrey from the UCSF Institute for Health Policy was introduced to the Panel.

- A project to assess the implementation of diabetes' disease management following the passage of SB 64 was presented to the Panel. Dr. Linares noted the Knox-Keene Act was amended by the bill; and plans are required to cover standard supplies, access to medications and educational as well as nutritional counseling. Complaints to the HMO Help Center have suggested there has been a wide variance in how plans have implemented these provisions; and delays and barriers to comprehensive and recognized diabetic management guidelines still exist. Dr. Bergman noted that there are reports and other evidence that gaps in coverage exist and is concerned that the Panel's efforts don't duplicate issues that have or are already being reviewed and studied.

  The Panel agreed with the recommendations put forth to improve preventive care for patients with diabetes and recommended that specific project work should be contracted out or partnerships established instead of forming work groups.

- Dr. Linares noted Blue Shield's open process to review medical policy and technology using evidence-based criteria and a specific method to assess changes in guidelines.

    - Dr. Alksne asked how practitioners were notified about the presentations and issues to be considered. Dr. Jonathan Friedman from Blue Shield described how issues are presented by medical groups and that the plan seeks to get all sides of the issue by contacting medical societies and specialty groups, if possible.

    - Dr. Panzarino noted there are differences between technology assessments performed by a plan and the state regulatory requirements. Dr. Freudman stated members of the medical policy committee are not paid by Blue Shield and the plan continues to extend invitations to the widest audience possible. He noted that without a single payor system bringing the disparate parties together without risking complaints of collusion is a challenge. Dr. Jeffrey Rideout from Blue Shield noted there is no value added to one plan having different policies than others, and they are actively seeking to increase the awareness of the process used by the plan.

- Dr. Schorr from the California Psychiatric Association, presented concerns that the impact of mental health parity legislation has decreased primary physician's access to qualified mental health providers. There has been what appears to be an arbitrary limit on the number of visits to psychiatrists, even though there is often a need to maintain continuity in patient management to monitor the treatment plan and prescriptions from an initial diagnosis and treatment plan. Formulary restrictions also unduly restrict providing the therapeutic agent best suited to the patient's needs and that avoid side effects. Prior authorization procedures usually will result in approvals but the time required may act as a deterrent. These issues are particularly critical with children who are developmentally delayed or autistic where there often is uncertainty of the plan's responsibility in relation to the school system or other pubic resources. The integration of mental health services and optimal delivery of care may not be best served by mental health carve-outs. Although convenient for the plans, this increasing practice should be reviewed to ensure it meets the need to fully integrate the mental and physical health needs of patients.

    - In response to a question from Dr. Berkoff, Dr. Schorr stated that the typical problem concerns the psychiatrist's ability to monitor and evaluate medications when the patient is seeing another therapist and is often left without adequate information on the overall effect and any changes. Collaboration and coordination should be emphasized and facilitated by all providers involved with the patient.

    - Dr. Panzarino noted this may be an unintended consequence of mental health parity, instead of increased integration of services; the co-morbidity of psychiatric and physical diagnoses can go unrecognized in making case management decisions.

    - Dr. Schorr stated there are shortages in the number of child psychiatrists on the mental health plan carve-out panels. There is a definite need for primary care physicians to integrate their care with those specialists' expertise to ensure effective preventative efforts and long-term care planning, particularly for those children with serious neuropsychiatric problems.

    - Dr. Alksne asked what impact the Panel might have with the issues raised. Dr. Linares stated this information will raise the Department's awareness and could lead to further study on whether the mental health services by some plans should be constructed differently to provide necessary continuity of care. Jim Tucker added that assessing the actual implementation of AB 88 by the industry could lead the Department to report back to the Legislature that its expectations may not have been met.

Next Steps

- Drs. Bergman, Savage and Berkoff discussed the role of the Panel in promoting evidence-based medicine and multi-disciplinary approaches to patient care. The role of the Panel in relation to the topics of diabetes' management and mental health parity was discussed in relation to the quarterly meetings of the group, which would not allow them to formulate and respond to the significant questions raised even in those two areas. Dr. Panzarino noted that managed care was supposed to offer the potential advantages of large data sets and allowing evidence-based and multi-disciplinary team approaches to medical care. Dr. Bergman suggested that the Department work with existing organizations that offer collaborative action and research on best practices. He recommended that the Department sponsor stakeholder meetings related to prevention and best practices in these areas.

Public Comment

- Kathy McCaffrey from the California Association of Health Plans, addressed the importance and complexities AB 88 presented, including whether the plan or public entities have responsibility for some types of care. The Association would welcome further discussion with Dr. Schorr and the California Psychiatric Association on the issues he presented.

- Joan Worblum from Citizens for Right to Know and a registered nurse, noted that efforts need to be focused in getting the word out about mental health parity and other patient rights' initiatives, at a reading level that enrollees can understand. This includes informing the human resource directors so they can be aware of what benefits they are buying for employees and what the plans are supposed to be providing. Diabetes also presents problems that continue to appear – changes were just announced at the federal level on whether Medicare + Choice plans had to pay for non-generic medications.

- Dr. Barry Straube, Medical Officer, HCFA Region IX, reviewed the role of HCFA and how questions directed to Medicare+Choice plans and medical coverage can be answered. He noted the long-standing collaboration HCFA has had with Medicare plans in the ICE process, has been successful to ensure consistency and proper implementation of changes which have occurred in Medicare in recent years. He also noted the oversight role HCFA has had with CHDR that has resulted in significant improvements in the external review process in the past three years. Dr. Straube outlined Medicare's technology assessment/medical policy decision processes as it occurs on the national and regional levels. He encouraged the Panel to develop a specific charter and to be specific about its goals as it goes forward.

- Dr. Wade Aubrey from the UCSF Institute of Health Policy, noted the Blue Shield technology-assessment process is different from other plans in its use of evidence-based criteria. The Stanford Medical Necessity Project showed wide variation in managed care's decision making and policies. Plans are doing very little to exchange even scientific information. Dr. Aubrey believes the Department can provide a forum together with CalPers and PBGH to bring needed attention when there are different standards applied to medical evidence and variations occur in coverage.

[Corrections or comments regarding these notes should be provided to Tom Gilevich, DMHC Counsel at (916) 324-9024; FAX (916) 322-3968 ; TGilevich@dmhc.ca.gov.]